MARYLAND BOARD OF PHARMACY
4201 PATTERSON AVE, BALTIMORE, MD 21215-2299
(410) 764-4755 (800) 542-4964 Md Only (410) 358-6207 Fax

CONTINUING EDUCATION PROGRAM APPROVAL FORM

BOARD USE ONLY

PROGRAM NUMBER **:** __ __ __ __ __ - __ __ - __ __ __

DATE APPROVED: __ __ - __ __ - __ __

EXPIRATION DATE: __ __ - __ __ - __ __

APPROVED CE CREDIT: ____ **HOURS:** ____

APPROVED BY: _____

DESCRIPTION: The program provider is directed to follow the guideline in completing this form. Incomplete forms may be returned for further information delaying program review and reply. You should submit this request at least 45 days before the date an answer is needed.

1. Names and address of organization or individual seeking approval:

_____
Name Date

_____
Address Telephone

_____
City State Zip

2. Name and address of individual responsible for continuing education program where this differs from #1:

_____
Name

_____
Address

_____
City State Zip

As a program provider do you agree to:	YES	NO
(a) maintain attendance records for this program?	____	____
(b) include name and address of participants on attendance records?	____	____
(c) maintain attendance records so that completion or hours completed will be shown?	____	____
(d) provide a certificate to each participant of satisfactory completion of the program which includes:	____	____
(1) Name of the participant:		
(2) Name of the provider:		
(3) Description of course work:		
(4) Number of hours:		
(5) Date of completion of program		
(6) An authorized signature and Program Identification Number (Board Approved Number) should be noted on the Certificate of Attendance		
	YES	NO
(e) make such attendance records available on request to participants or board for six years after completion of program?	____	____

3. Do you agree to:	YES	NO
(a) maintain description of content of this program?	____	____
(b) make program description available to participant or board for six years after completion of last program presentation?	____	____
(c) submit a copy of a summary of the evaluation		

results if requested to do so? ____ ____

4. PROGRAM TITLE:_____

5. DESCRIPTION OF PROGRAM:

(a) Program Site : _____

(b) Program date (s) :_____

(c) Number & length of program units : _____

(d) Type: (seminar, correspondence, etc.) _____

(e) Duration of total program:_____
(for seminar, study group, etc.) _____ contact hours
(for self-study programs) _____ estimate study time.

(f) Nature of audience for whom program is prepared:

(g) Number of attendees anticipated:

6. Program Goals:

7. Program Learning Objectives:

8. How will the program be presented? (e.g., lecture, panel, discussion group, workshop, group study session, private study, etc.)

9. What types of audio/visual aids will be used? (Please check those which are applicable.)

____ Slides ____ Films ____ Video tapes

____ Exhibits ____ Audio cassette tapes ____Charts

Other (describe):

_____

_____

_____

		YES	NO
10.	Will program outlines be made available to participants?	____	____
11.	Will case histories be used in the program?	____	____
12.	Will an annotated reading list be made available?	____	____

13. PROGRAM FACULTY & QUALIFICATIONS (attach additional information, if appropriate):

Name: _____ Position: _____

_____

_____

14. Describe the methods to be used in evaluation of this program in terms of procedures, processes, and results (Attach copy of evaluation form to be used):

15. OTHER INFORMATION WHICH YOU MAY WISH TO RELATE:

16. Please enclose promotional brochures, program schedule, materials, outlines, etc.

PERSON COMPLETING THIS FORM:

Name (Print or type)

Address

City State Zip

Telephone Number (HOME) (WORK)

Signature Date

Please return this completed form to:

Maryland Board of Pharmacy
4201 Patterson Avenue
Baltimore, MD 21215-2299

Web site: www.mdbop.org

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